STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00093528. Complaint IN00093528 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-282. Survey date: August 11, 2011 Facility number: 000418 Provider number: 155565 AIM number: 100274870 Survey team: Debra Skinner RN Census bed type: SNF/NF: 48 Total: 48 Census payor type: Medicare: 03 Medicaid: 38 Other: 07 Total: 48 Sample: 03 These deficiency also reflects state findings in accordance with 410 IAC 16.2. Quality review 8/15/11 by Suzanne	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0282 SS=D	Williams, RN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician's orders regarding the discontinuation of a resident's sliding scale for insulin coverage which had resulted in the administration of insulin one time only for that resident's high blood sugar. This deficient practice affected 1 resident reviewed for insulin administration in a sample of 3 (Resident #A). Findings include: Review on 08/11/11 at 10:45 a.m., of Resident #A's clinical record indicated: Resident #A had the diagnoses which included multiple sclerosis, depressive disorder, hypertension, insulin dependent diabetes, schizophrenia, and neuropathy. Physician's orders for August 2011 included, but were not limited to: Accuchecks q (every) morning (06/23/11) Humalog insulin inject 5 units SQ (subcutaneously) three times daily with meals (03/25/11)	F0282	This Plan of Correction constitutes the written allegation of compliance for the Deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirement established by state and federal law.Hickory Creek at Sunset desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance effective 9/10/11.It is the policy of this facility to follow physician's orders, including the discontinuation of sliding scale insulin.1. What corrective actions were accomplished for the resident found to have been affected by the deficient practice?Resident A's August Medication Administration Record (MAR), was reviewed by the DON and MDS Coordinator to ensure that all physician orders were transcribed accurately. No additional transcription errors were noted.2. What corrective action will be taken for other residents identified?MARS and physician orders of current residents were reviewed by the DON and MDS coordinator; no other Physician order transcription errors were	09/10/2011

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	Lantus insulin inject 37 units SQ daily at bedtime (03/25/11) Glucophage (Metformin) 500 mg (milligrams) po (by mouth) two times daily (05/16/11) A telephone order dated 06/23/11 indicated: "D/C (discontinue) sliding scale insulin, D/C current accuchecks, start accuchecks q a.m. (morning)." A glucometer blood sugar check record indicated on 07/05/11, the resident's blood sugar had been 191. A MAR (medication administration record) for July 2011 indicated the resident's blood sugar reading had been 191 on 07/05/11, with the resident having received 5 units of Humalog insulin for coverage. This MAR indicated the order for sliding scale with Humalog insulin for coverage had been carried forward to the July 2011 MAR with staff having continued to follow this order until 07/12/11. This document indicated no other blood sugar readings which would have been subject to the resident having required insulin for coverage except on 07/05/11. During interview on 08/11/11 at 4:15		noted.However if any errors in follow through of physcian orders are identified, the DON will ensure that the physician is contacted as quickly as possible so that any needed treatment will be put into place.Once the resident has been taken care of, the DON will re-train the nurse(s) involved regarding the facility policy and procedure for the physician order transcription and follow through. Progressive disciplinary action will also be rendered as deemed necessary at the time.3. What systemic changes will be put into place to ensure that the deficient practice does not recur?The upcoming months' MARs are received on or about the 23rd of the current month. The DON/MDS/SDC will collectively review the MARs to assure all physicians orders are transcribed accurately.After review the MARs will be available at the nurses' station for the nurses to document any new orders received prior to the month end change over.The DON will be immedicately notified of any discrepancies and she will follow through as indicated in question #2.The DON will re-educate the licensed staff regarding the process of transcription of telephone orders by August 29, 2011.4. How will the corrective action be monitored?Any applicable information to be placed on the MARs will be monitored by nursing	

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	p.m., the administrator indicated the resident's family had been notified of this incident which had been found on 07/13/11, but had not reported it as a medication error as the resident had no adverse side effects from having received the insulin for coverage as the resident's blood sugar had been high at the time on 07/05/11, with the amount of insulin having been the correct amount of insulin the resident would have received had the sliding scale order still been in place. This Federal tag relates to Complaint IN00093528. 3.1-35(g)(2)		administration at least 5 days a week immediately following the morning management meeting. The new MARs will be reviewed at the morning management meeting which occurs at least 5 days a week along with the telephone orders to assure all new orders received prior to the change over are correctly recorded on the new MARs. In addition, on an ongoing basis the night nurse will review all new orders (24 hour chart check) to ensure accurate transcription to the MAR.The DON will bring the results of the monitoring efforts for review at the Quality Assurance meeting on a monthly basis for three months. At the end of that three months, the QA Committee members may decide to end the DON's documented monitoring activities when the facility has reached 100% compliance. Even when the QA committee no longer requires the documented monitoring by the DON, she or her designee will continue to follow through on the process for assuring physician orders are transcribed correctly on an ongoing basis.	